

4130. COMPARABILITY OF SERVICES

A. Background.--Under §1902(a)(10)(B) of the Social Security Act (the Act) and implementing regulations at 42 CFR 440.240, services available to any categorically needy recipient under a State plan must not be less in amount, duration, and scope than those services available to a medically needy recipient. Services available to any individual in the categorically needy group or a covered medically needy group must be equal in amount, duration, and scope for all recipients within the same group. Comparability requirements ensure that coverage of services for the categorically needy continue to be the primary objective of the Medicaid program and prevent the coverage of selected services for the medically needy from diverting resources from the categorically needy. Also, these requirements ensure that each Medicaid individual receives a fair and equitable share of services covered under the State Medicaid plan, and that no individual is prevented arbitrarily from receiving a service once determined to be a member of an eligible coverage group.

In the past, various legislative provisions have been enacted to permit or require that exceptions be made to these comparability requirements. The purpose was to permit flexibility in targeting needed medical services to those individuals who required them while, at the same time, ensuring that the intent of the Medicaid program was upheld.

B. Exceptions.--Effective April 7, 1986, §9501(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272) provides an exception to the comparability requirements with respect to additional services made available to pregnant women. Under this exception, you may elect to provide additional services (expansion of coverage) to pregnant women eligible for receiving Medicaid without violating comparability requirements. The only stipulation is that these additional services must be available to all Medicaid pregnant women, however, you do not have to extend them to other individuals or groups.

Additional services for pregnant women would be directed toward the rendition of pregnancy-related services (prenatal, delivery and post-partum) and services for conditions which may complicate pregnancy. These additional services may be comprised of the following:

- o greater coverage of existing plan services (required or optional); and
- o coverage of optional services not otherwise covered under the plan.

Accordingly, you may establish less restrictive limitations on existing plan services which would allow for increased medical care being made available only to Medicaid pregnant women (e.g., you may wish to provide additional inpatient hospital care or physician care by allowing coverage for additional inpatient days or physician visits). You may also extend coverage for preventative and curative services not presently covered under your Medicaid plan only to your Medicaid pregnant women. These may be services which are currently optional under §§1905(a)(9) and (13) of the Act, including health education and outreach services, clinic services, nutrition counseling, vitamins and other over-the-counter medications, etc.

The following example is an illustration of the use of the comparability exception to expand coverage for pregnant women: If you wish to provide prescribed drugs (an optional service not otherwise available under your plan) and 10 additional days of inpatient hospital care (expansion of a plan limitation on a required service) to your medically needy pregnant women, you would be required to provide comparable benefits to your categorically needy pregnant women, but would not be required to provide these benefits to the entire medically needy and categorically needy populations.

4201. ORGAN TRANSPLANTS

A. Background.--Section 1903(i) of the Social Security Act requires the denial of Federal Financial Participation (FFP) for organ transplants unless the State plan provides written standards concerning the coverage of such procedures. The statute does not list the transplant procedures for which standards must be written, but the organs about which questions are most commonly asked are: cornea, kidney, heart, liver, bone marrow, pancreas and combined heart-lung. You can choose to cover no organ transplant procedures, some types of transplants and not others, or all transplants. You should specify in the written standards which organs you cover and any special conditions or limitations which apply to them.

B. Standards for Coverage.--If you choose to cover organ transplant procedures, furnish written standards for the coverage of these procedures which provide that:

- o similarly situated individuals are treated alike;
- o any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; and
- o services are reasonable in amount, duration, and scope to achieve their purpose.

1. Similarly Situated Individuals.--Similarly situated does not mean that anyone with end-stage organ disease, regardless of the etiology, must be covered. Apply transplant criteria fairly and uniformly to all individuals eligible for Medicaid. There is no justification for approving payment for a particular transplant procedure for one eligible recipient and denying payment for that same procedure for another similarly situated eligible recipient needing the same transplant procedure. You may, however, place limitations on coverage. For example, you can choose to cover transplants for the categorically needy, and not cover them for the medically needy. You can also choose to limit coverage to certain clinical conditions or to reasonable patient selection criteria. However, include these conditions in your standards. Do not list general statements such as "coverage is limited to those conditions for which the safety and efficacy of the transplant have been established," or "coverage is limited to nonexperimental procedures," as coverage standards.

2. Facility and Practitioner Restrictions.--In view of the extraordinary expense and complexity of transplant procedures, you can decide to commit your resources only to those facilities and practitioners of demonstrated excellence with regard to a particular procedure, whether located in your State or not. If you choose to restrict the facilities or practitioners, assure that the designated providers render high quality care and that they are accessible, through transportation arrangements made or paid for by the State, to all eligible Medicaid recipients throughout the State.

3. Sufficiency of Services.--Under regulations at 42 CFR 440.230, you are prohibited from "arbitrary" denial or reduction of an eligible recipient's benefits, but you are permitted to place appropriate limits based on medical necessity. You may cover transplants up to a dollar or day limit, and may refuse to continue coverage beyond such limits, even if the patient is currently in a transplant program. However, any limits applicable to transplants, whether in terms of dollars or days, should be reasonably related to the dollars or days necessary to cover the particular type of transplant for most transplant patients in the Medicaid-eligible population. For example, if the average hospital stay for a type of transplant is 30 days, a limit of 14 days would not be considered reasonable, even though such a limit might be acceptable for nontransplant patients. By the same token, you may provide additional coverage for transplant patients above normal State plan limits, and this would not constitute an arbitrary denial or reduction in services for other (nontransplant) recipient groups.

4221. OUTPATIENT PSYCHIATRIC SERVICES.

A. General.--Medicaid provides coverage of various types of organized outpatient programs of psychiatric treatment. These programs are covered primarily as either outpatient hospital services (42 CFR 440.20(a)) or as clinic services (42 CFR 440.90). Problems have sometimes arisen regarding outpatient programs which inappropriately billed Medicaid for chance, momentary social encounters between a therapist and a patient as if they were valid therapeutic sessions. There have also been instances of billing for services without sufficient documentation to establish that the services were clearly related to the patient's psychiatric condition. With the ongoing effort to encourage furnishing psychiatric treatment in the least restrictive setting possible, there is an increasing need for coverage guidelines specifically directed at outpatient programs. The following guidelines can help to ensure appropriate utilization with regard to outpatient psychiatric programs.

B. Outpatient Program Entry.--An intake evaluation should be performed for each recipient being considered for entry into an outpatient psychiatric treatment program. This applies to any organized program or course of treatment that a recipient enters or attends to receive scheduled or planned outpatient psychiatric services. The evaluation is a written assessment that evaluates the recipient's mental condition and, based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate.

The evaluation team should include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified). For each recipient who enters the program, the assessment should include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs. The assessment should be made a part of the patient records.

C. Treatment Planning.--For each recipient who enters the outpatient program, the evaluation team should develop an individual plan of care (PoC). This consists of a written, individualized plan to improve the patient's condition to the point where the patient's continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The PoC is included in the patient records, and contains a written description of the treatment objectives for that patient. It also describes:

1. the treatment regimen--the specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives;
2. a projected schedule for service delivery--this includes the expected frequency and duration of each type of planned therapeutic session or encounter;
3. the type of personnel that will be furnishing the services; and
4. a projected schedule for completing reevaluations of the patient's condition and updating the PoC.

D. Documentation.--The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material which includes:

1. the specific services rendered;
2. the date and actual time the services were rendered;
3. who rendered the services;
4. the setting in which the services were rendered;
5. the amount of time it took to deliver the services;
6. the relationship of the services to the treatment regimen described in the PoC and
7. updates describing the patient's progress.

For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

E. Periodic Review.--The evaluation team should periodically review the recipient's PoC in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team should perform such reviews on a regular basis (i.e., at least every 90 days) and the reviews should be documented in detail in the patient records, kept on file and made available as requested for State or Federal assessment purposes.

4231. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND OTHER AMBULATORY SERVICES

A. Background.--Section 6404 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) amended §§1905(a) and (l) of the Social Security Act to provide for coverage and definition of Federally Qualified Health Center (FQHC) services and other ambulatory services offered by an FQHC under Medicaid. Payment for services added by §6404 is effective for services provided on or after April 1, 1990. Payment for FQHC services is discussed in §6303.

B. FQHC Services and Other Ambulatory Services.--FQHC services are defined the same as the services provided by rural health clinics (RHCs) and generally described as RHC services. These services include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. In certain cases, services to a homebound Medicaid patient may be provided. For a discussion of RHC services, see the Medicare Rural Health Clinic Manual, Chapter IV. Any other ambulatory service included in a State's Medicaid plan is considered a covered FQHC service, if the FQHC offers such a service.

C. Qualified FQHCs.--FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. For purposes of providing covered services under Medicaid, FQHCs may qualify as follows:

- o The facility receives a grant under §§329, 330, or 340 of the Public Health Service (PHS) Act;
- o The Health Resources and Services Administration (HRSA) within the PHS recommends, and the Secretary determines that, the facility meets the requirements for receiving such a grant; or
- o The Secretary determines that a facility may, for good cause, qualify through waivers of the requirements described above. Such a waiver cannot exceed a period of 2 years.

A list of facilities receiving grants under §§329, 330, and 340, and thereby automatically qualified for provision of and payment for services provided under this section, is found in Exhibit I immediately following this section. The PHS advises HCFA timely of changes in status of grantees and other qualified FQHCs.

Any entity seeking to qualify under this section which does not qualify as a grant receiving facility should contact the PHS for consideration. The PHS is responsible for determining whether an applicant meets eligibility requirements. Applicants for consideration generally must be free-standing entities providing ambulatory care which otherwise qualify under §§329, 330 or 340 of the PHS Act. PHS forwards to HCFA, as determinations are made, a list of qualified entities. HCFA is responsible for the final determination that a facility (other than a grant recipient) can receive payment for services under Medicaid, and will notify states accordingly. Applicants apply to:

Director, Division of Primary Care Services
Bureau of Health Care Delivery and Assistance
U. S. Public Health Service
Room 7A55
5600 Fishers Lane
Rockville, MD 20857

Additionally, an FQHC which is not physician-directed may make certain arrangements similar to those entered into by RHCs, as provided for in § 1861(aa)(2)(B) of the Act. These arrangements concern reviews, supervision and guidance of non-physician staff, preparation of treatment orders, consultation, medical emergencies, and certain other certifying requirements for such facilities. The PHS assures the non-physician directed FQHCs comply with the requirements of §1861 (aa)(2)(B) of the Act.

D. Effective Date.--April 1, 1990 is the effective date for services provided under §6404 of OBRA-89. Submit State plan amendments to the HCFA regional offices no later than June 30, 1990, in order to obtain approval for services provided on or after the effective date. However, when the Secretary determines that State legislation (other than for funding) is necessary in order for the plan to meet the additional requirements of §6404, the State plan is out of compliance only if it fails to comply with such additional requirements after the first day of the first calendar quarter beginning after the close of the first regular session of a State legislature that begins after the date of the enactment of OBRA-89 (December 19, 1989). In a State that has a 2 year legislative session each year of the session is deemed to be a separate regular session of the State legislature.

Exhibit I

FY 1990 CH/MHC Grantee List

90	R	BDT	E	ST	G	MO	BCRR	PROG	NAME	CITY	ST
01	08	010810	U						SW Community	Bridgeport	CT
01	03	011270	U						Bridgeport Comm	Bridgeport	CT
01	03	011260	U						Community Health	Hartford	CT
01	01	011830	U						Charter Oak Terrace	Hartford	CT
01	06	010070	U						Hill Health Corp	New Haven	CT
01	04	010060	U						Fairhaven Comm Health	New Haven	CT
01	08	010290	U						Roxbury Comp Comm.	Boston	MA
01	07	010160	U						North End Comm Hlth	Boston	MA
01	02	011890	U						Joseph Smith CHC	Boston	MA
01	07	010170	U						Harbor Health Svcs	Boston	MA
01	04	012010	U						Mattapan Comm Hlth	Boston	MA
01	07	010710	U						South Cove Comm.	Boston	MA
01	02	010030	U						Holyoke Health Ctr,	Holyoke	MA
01	07	012160	U						Greater Lawrence	Lawrence	MA
01	08	011460	U						Lowell Community	Lowell	MA
01	03	011430	U						Lynn Community	Lynn	MA
01	07	011930	U						Greater New Bedford	New Bedford	MA
01	08	010860	U						North Shore Comm Hlth	Peabody	MA
01	03	011190	R						Outer Cape Health	Provincetown	MA
01	06	011640	U						Manet Comm Hlth Ctr	Quincy	MA
01	08	010800	U						Family Health &	Worcester	MA
01	06	010830	U						Great Brook Valley	Worcester	MA
01	06	010330	R						Worthington Health	Worthington	MA
01	07	010040	R						Rural Health Centers	Augusta	ME
01	02	012030	R						Bethel Area HC	Bethel	ME
01	07	010340	R						Bucksport Reg Hlth	Bucksport	ME
01	06	011230	R						Sacopee Valley	Kezar Falls	ME
01	12	010380	R						Reg. Medical Center	Lubec	ME
01	12	010420	R						Northern ME Rural	Presque Isle	ME
01	07	010460	R						Kennebec Valley	Waterville	ME
01	05	011580	R						Lamprey Health Care	New Market	NH
01	12	012230	R						Wood River Hlth	Hope Valley	RI
01	01	012240	U						Blackstone Valley	Pawtucket	RI
01	12	010580	U						Providence Ambul.	Providence	RI
01	03	011820	R						Thundermist Hlth Assoc,	Woonsocket	RI
01	07	010640	R						Northern Co. Health	St. Johnsbury	VT
02	01	021270	R/MH						Bridgeton Area	Bridgeton	NJ
02	01	021280	U						Camcare Health	Camden	NJ
02	03	020930	R/MH						Sa-Lantic Health	Hammonton	NJ

Exhibit I(Cont.)

02	04	022290	U	Jersey City Medical	Jersey City	NJ
02	12	020500	U	Newark Comm Hlth Ctr	Newark	NJ
02	01	021300	U	Paterson CHC Network	Paterson	NJ
02	07	021230	U	Plainfield Health	Plainfield	NJ
02	04	020070	U	Henry J. Austin	Trenton	NJ
02	04	020110	U	Whitney M. Young	Albany	NY
02	01	020180	R/MH	Oak Orchard Comm.	Brockport	NY
02	08	021950	U	Soundview Health	Bronx	NY
02	06	021610	U	Morris Heights	Bronx	NY
02	02	020760	U	Bronx Ambulatory	Bronx	NY
02	01	020270	U	Sunset Park	Brooklyn	NY
02	12	021210	U	ODA Primary Care	Brooklyn	NY
02	01	020610	U	CHC East New York	Brooklyn	NY
02	12	022050	U	L B Johnson Health	Brooklyn	NY
02	04	021980	U	Brooklyn Plaza	Brooklyn	NY
02	01	020010	U	North West Buffalo	Buffalo	NY
02	08	021310	R	North Jefferson	Clayton	NY
02	12	021240	R	Cortland Co. Rural	Cortland	NY
02	08	021530	U	Greenburgh Neigh'bd HC	Greenburg	NY
02	08	021500	U	Mt. Vernon N.H.C	Mt. Vernon	NY
02	08	021080	U	Settlement Hlth and	New York	NY
02	12	020390	U	East Harlem Cl. for	New York	NY
02	12	020490	U	William F. Ryan	New York	NY
02	05	021390	U	Chinatown CHC	New York	NY
02	06	020620	U/MH	Fam HC of Orange &	Newburgh	NY
02	08	021520	U	Ossining Open Door HC	Ossington	NY
02	08	021510	U	Peekskill Hlth Ctr	Peekskill	NY
02	01	020870	R	Northern Oswego	Pulaski	NY
02	04	022110	U	Joseph P. Addabbo	Queens	NY
02	01	022070	U	Anthony L. Jordan	Rochester	NY
02	01	020560	U	Rochester Primary	Rochester	NY
02	06	021830	U	Carver Community	Schenectady	NY
02	01	020570	MH	Rochester Gen. Hosp	Sodus	NY
02	04	020160	U	Syracuse Community	Syracuse	NY
02	01	021790	R	Hudson Headwaters	Warrensburg	NY
02	07	021870	R	Barceloneta RH	Barceloneta	PR
02	02	020910	R	Camuy RHI	Camuy	PR
02	05	020660	R/MH	Hosp General de	Castaner	PR
02	03	021250	R	Ciales Health Ctr	Ciales	PR
02	03	020730	MH	Cidra Migrant	Cidra	PR
02	01	021400	R	Florida RHI Hlth Ctr	Florida	PR
02	03	021260	R	Hatillo RHI	Hatillo	PR
02	05	022090	R	Lares Health Center	Lares	PR

Exhibit I(Cont.)

02	07	020670	R/MH	Loiza Comprehensive	Loiza	PR
02	03	021040	MH	Mayaguez Migrant Hlth	Mayaguez	PR
02	06	020650	R/MH	Central Areawide	Naranjito	PR
02	04	020890	R/MH	Patillos RHI	Patillas	PR
02	12	020680	U/MH	Ponce Diagnostic	Playa Ponce	PR
02	05	021030	R	Rincon RH Project	Rincon	PR
02	05	020700	U	Dr. J. S. Belaval	Rio Piedras	PR
02	06	021350	R	Fredericksted Hlth	St. Croix	VI
03	02	031860	U	Community Health Care	Washington	DC
03	04	030070	MH	Delmarva Rural	Dover	DE
03	03	031260	U	Southbridge Medical	Wilmington	DE
03	02	033180	U	Baltimore Medical	Baltimore	MD
03	04	031270	U	South Baltimore	Baltimore	MD
03	07	032810	U	Assoc. Program for	Baltimore	MD
03	12	030150	U	West Baltimore	Baltimore	MD
03	12	030130	U	Parkwest Health	Baltimore	MD
03	07	032750	R	Caroline Hlth	Goldsboro	MD
03	12	031600	R	Tri-State CHC	Hancock	MD
03	06	030170	R	Somerset Co for	Princess Anne	MD
03	06	031220	R	North Penn Comp	Blossburg	PA
03	03	030220	R	Broadtop Area	Broad Top City	PA
03	03	030230	R	Comm. Medical Ctr	Burgettstown	PA
03	02	033930	U	Ches Penn Health	Chester	PA
03	08	032430	R	Glendale Area Med.	Coalport	PA
03	04	032300	R	Keystone Rural	Emporium	PA
03	07	034230	U	Primary Hlth Svcs of	Erie	PA
03	03	034060	R	Shenango Valley Pri.	Farrell	PA
03	02	031700	R	Centerville Clinics	Fredericktown	PA
03	04	033090	R	SE Greene Community	Greensboro	PA
03	04	030290	U	Hamilton Health Ctr	Harrisburg	PA
03	05	031880	MH	Rural Opport.,Inc	Harrisburg	PA
03	03	032440	R	Hyndman Area Medical	Hyndman	PA
03	04	033620	U	SE Lancaster Primary	Lancaster	PA
03	12	032230	U	F.O.R. Sto-Rox NHC	McKees Rocks	PA
03	03	034140	U	Spectrum Health	Philadelphia	PA
03	06	032900	U	Philadelphia Health	Philadelphia	PA
03	06	033780	U	Quality Health	Philadelphia	PA
03	06	033200	U	Greater Philadelphia	Philadelphia	PA
03	12	032220	U	Covenant House Hlth	Philadelphia	PA
03	02	030440	U	Primary Care Health	Pittsburgh	PA
03	12	032560	U	Scranton Primary	Scranton	PA
03	05	030480	R	Barnes Kasson Health	Susquehanna	PA
03	07	030560	R	Rural Hlth Corp of NE	Wilkes Barre	PA

Exhibit I(Cont.)

03	04	031160	U	York Health Corp.	York	PA
03	06	030720	R	Eastern Shore Rural	Accomac	VA
03	03	031970	R	Brunswick Health	Alberta	VA
03	03	032380	R	Tri County Medical	Aylett	VA
03	03	032650	R	Bland County Medical	Bastian	VA
03	08	034170	R	Boydton Comm Hlth	Boydton	VA
03	06	031230	R	Clinch River Health	Dungannon	VA
03	05	033030	R	Western Lee County	Ewing	VA
03	05	032840	R	Ivor Community	Ivor	VA
03	08	034180	R	Lunenburg Co. Health	Kenbridge	VA
03	08	033230	R	Tri - Area Laurel	Laurel Fork	VA
03	08	034050	R	Blue Ridge Health	Lovington	VA
03	08	030700	R	Central Virginia	New Canton	VA
03	05	032240	U	Peninsula Institute	Newport News	VA
03	03	031810	R	Saltville Medical	Saltville	VA
03	06	030740	R	St Charles Council	St Charles	VA
03	03	031760	R	Stony Creek CHC	Stony Creek	VA
03	06	033130	R	E.A. Hawse Retirement	Baker	WV
03	06	030880	R	Valley Hlth Systems,	Barboursville	WV
03	06	030800	R	Clay-Battelle Hlth	Blacksville	WV
03	12	033100	R	Camden-on-Gauley	Camden-on-Gauley	WV
03	12	034090	R	Clay Co Primary Hlth	Clay	WV
03	12	031820	R	Cabin Creek Health	Dawes	WV
03	02	030820	R	Monongahela Valley	Fairmont	WV
03	03	031000	R	Tug River Health	Gary	WV
03	07	034190	R	Minnie Hamilton Hlth	Grantsville	WV
03	06	032580	R	No. Greenbrier/South	Hillsboro	WV
03	06	030890	R	Preston-Taylor CHCs	Kingwood	WV
03	07	030900	R/MH	Intercounty Hlth,	Martinsburg	WV
03	06	031250	R	Bluestone Health	Princeton	WV
03	12	033080	R	Rainelle Medical Center	Rainelle	WV
03	12	034210	R	Tri-County Health	Rock Cave	WV
03	12	032600	R	New River Health	Scarbro	WV
03	02	034120	R	Roane County Family	Spencer	WV
03	04	030790	R	Community Hlth System	Sprague	WV
03	08	030990	R	Monroe Co. Hlth Bd	Union	WV
04	04	042210	R	Autaugaville Medical	Autaugaville	AL
04	02	040070	R	West Alabama Neigh-	Eutaw	AL
04	02	042830	R	Conecuh Medical	Evergreen	AL
04	04	044120	U	Etowah Quality of	Gadsden	AL
04	03	044700	U	Area Health Dev. Bd	Irvington	AL
04	03	048190	U	Central North Ala.	Madison	AL
04	08	044710	U	Franklin Memorial	Mobile	AL
04	06	047080	U	Mobile Co Hlth Dept	Mobile	AL
04	02	040130	U	Montgomery Hlth Svcs	Montgomery	AL
04	12	042180	R	Southern Rural Hlth	Russellville	AL
04	06	045710	R	Jackson Co Primary	Scottsboro	AL

Exhibit I(Cont.)

04	07	042850	R	Rural Hlth Medical	Selma	AL
04	05	048950	R	SE Alabama RHA	Troy	AL
04	12	042450	R	Maude L. Whately	Tuscaloosa	AL
04	08	040040	R	Health Development	Tuscaloosa	AL
04	04	040160	R	Central Alabama	Tuskegee	AL
04	02	041660	R/MH	West Orange Farm	Apopka	FL
04	07	040200	R	Family Medical	Cross City	FL
04	03	045500	R/MH	East Pasco Hlth Ctr,	Dade City	FL
04	02	040210	R/MH	Florida Rural Hlth	Frostproof	FL
04	03	041680	R/MH	Southwest FL Hlth Ctr	Ft Myers	FL
04	02	048960	R	Tri County Health	Greenville	FL
04	04	041700	R/MH	Collier Health	Immokalee	FL
04	08	048970	U	Columbia Co. Health	Lake City	FL
04	05	040290	R	Lafayette Co.	Mayo	FL
04	08	041630	U	Coconut Grove Family	Miami	FL
04	02	040330	U	Economic Opport.	Miami	FL
04	02	040320	U/MH	Community Hlth	Miami	FL
04	02	040310	U	Borinquen Hlth Care	Miami	FL
04	04	044130	U	Stanley C. Myers	Miami Beach	FL
04	12	040340	R/MH	Rural Health Care,	Palatka	FL
04	12	044310	R/MH	Manatee Co. Rural	Parrish	FL
04	01	041670	U	Sunshine Health	Pompano Beach	FL
04	12	044780	R/MH	Gadsden Primary Care	Quincy	FL
04	04	041750	R/MH	Ruskin Migrant & CHC	Ruskin	FL
04	01	041720	R	Central Florida	Sanford	FL
04	06	049070	R	Johnnie Ruth Clark	St. Petersburg	FL
04	04	040250	R	Project Health, Inc.	Sumterville	FL
04	04	0412810	R	Tampa Community Hlth	Tampa	FL
04	07	042710	R	Trenton Medical	Trenton	FL
04	04	040370	R/MH	Florida Comm Hlth	West Palm Beach	FL
04	01	041740	R/MH	Bd of Co Commiss.	West Palm Beach	FL
04	08	040380	R	Wewahitchka Medical	Wewahitchka	FL
04	06	044150	U	Albany Area Primary	Albany	GA
04	06	040400	U	Health South, Inc.	Atlanta	GA
04	07	040410	U	West End Medical Ctr	Atlanta	GA
04	04	040390	R	Northeast Georgia	Crawford	GA
04	08	047430	R	Georgia Highlands	Cumming	GA
04	01	046900	U	Oakhurst Community	Decatur	GA
04	08	049170	MH	Candler County Hlth	Metter	GA
04	06	045260	U	Palmetto Health	Palmetto	GA
04	03	043340	R	Stewart-Webster	Richland	GA
04	08	040490	U	Westside-Urban Hlth	Savannah	GA
04	03	048160	R	Hancock Co Primary	Sparta	GA
04	12	042110	R	Georgia Mountains	Suches	GA
04	02	044790	R	Primary Hlth Care	Trenton	GA
04	05	042390	R	Tri-County Health	Warrenton	GA

Exhibit I(Cont.)

04	08	046980	R	Pike Co. Primary	Zebulon	GA
04	03	044090	U	Northern Kentucky	Covington	KY
04	08	048140	U	Lexington-Fayette Co	Lexington	KY
04	12	046840	U	Louisville Mem Prim	Louisville	KY
04	12	040650	U	Park Duvalle Hlth	Louisville	KY
04	06	044820	R	Health Help, Inc.	McKee	KY
04	02	040670	R	Big Sandy Health	Prestonsburg	KY
04	12	048980	R	Lewis County Primary	Vanceburg	KY
04	05	040600	R	Mountain Comp	Whitesburg	KY
04	05	049100	R	North Benton Co.	Ashland	MS
04	01	042430	R	Coastal Fam Hlth	Biloxi	MS
04	03	042440	U	Rankin Urban Hlth	Brandon	MS
04	05	043060	R	NE Mississippi	Byhalia	MS
04	06	040760	R	Madison Yazoo Leake	Canton	MS
04	06	046150	R	Aaron E. Henry	Clarksdale	MS
04	06	048800	R	Jefferson Compre.	Fayette	MS
04	08	040750	U	Jackson-Hinds Comp Hlth	Jackson	MS
04	05	040570	R	South Mississippi CHC	Laurel	MS
04	08	044470	R	Greene Area Medical	Leaksville	MS
04	03	045780	R	Amite County Med.	Liberty	MS
04	04	042070	R	Greater Meridian	Meridian	MS
04	03	040780	R	Delta Health Center	Mound Bayou	MS
04	07	040770	R	South Central MS	New Hebron	MS
04	07	048420	R	Claiborne Co. Comm.	Port Gibson	MS
04	04	042720	R	East Central MS Hlth	Sebastopol	MS
04	03	045770	R	SE Mississippi RHI,	Seminary	MS
04	06	048870	R	Outreach Health	Shubuta	MS
04	03	046860	R	Three Rivers Area	Smithville	MS
04	12	047330	R	S. W. Hlth Agency	Tylertown	MS
04	04	040840	R	Vicksburg-Warren CHC,	Vicksburg	MS
04	12	041940	R	Tri-County Hlth	Aurora	NC
04	12	040890	R	Orange Chatham Comp	Carrboro	NC
04	05	047770	U	Metrolina Comp	Charlotte	NC
04	07	040910	U	Lincoln CHC/Durham	Durham	NC
04	01	045800	R/MH	Goshen Medical	Faison	NC
04	04	040940	R/MH	Migrant Family Hlth	Hendersonville	NC
04	07	046610	R	Twin Co Rural Health	Hollister	NC
04	12	045200	R	Western Med Group/Boone	Mamers	NC
04	06	045810	R	Morven Area Medical	Morven	NC
04	04	040900	R/MH	Tri-County Comm.	Newton Grove	NC
04	08	049000	R	Robeson Health	Pembroke	NC
04	03	040860	MH	Migrant Hlth Program	Raleigh	NC
04	12	041000	U	Wake Hlth Svcs, Inc.	Raleigh	NC

Exhibit I(Cont.)

04	06	046800	R	Person Fam Med Ctr	Roxboro	NC
04	12	041020	R	Greene Co. Hlth Care,	Snow Hill	NC
04	03	041060	R	Vance Warren Comp.	Soul City	NC
04	03	046910	R	Stedman Wade Hlth	Wade	NC
04	05	049190	R	Bertie County Rural	Windsor	NC
04	08	044920	R	Caswell Family	Yanceyville	NC
04	02	042310	R	Calhoun Falls Area	Calhoun Falls	SC
04	05	041110	U	Franklin C. Fetter	Charleston	SC
04	08	045220	R	Rural Health Svcs,	Clearwater	SC
04	05	041090	MH	SC Mig. Hlth Proj.	Columbia	SC
04	05	047000	R	Britton's Neck Hlth	Conway	SC
04	02	040110	R	Midlands Primary	Eastover	SC
04	05	043770	R	Allendale Co.- Rural	Fairfax	SC
04	06	047060	R	Little River Medical	Little River	SC
04	07	045050	R	Sandhills Medical	McBee	SC
04	05	048430	R	St James - Santee	McClellanville	SC
04	03	046930	R	Black River	Olanta	SC
04	12	041180	R	Orangeburg Co.	Orangeburg	SC
04	06	041190	R	Beaufort Jasper	Ridgeland	SC
04	06	045230	R	Society Hill Family	Society Hill	SC
04	06	042780	R/MH	Megals Rural Hlth	Trenton	SC
04	02	041230	R/MH	Benton Medical	Benton	TN
04	12	041260	U	Chattanooga Hamilton	Chattanooga	TN
04	02	042160	R	Laurel Fork - Clear	Clairfield	TN
04	04	041780	R	Upper Cumberland	Cookville	TN
04	07	041440	R	Mountain Peoples	Huntsville	TN
04	05	041370	R	Perry County	Linden	TN
04	04	047820	R	Union Grainger	Maynardville	TN
04	01	041410	U	Memphis Health	Memphis	TN
04	05	049040	R	Stewart Co./Tenn Dpt	Nashville	TN
04	02	041420	U	Matthew Walker	Nashville	TN
04	02	044110	U	United Neighborhood	Nashville	TN
04	04	046810	R	Rural Community	Parrottsville	TN
04	05	0412790	R	Rural Hlth Svcs Cons.	Rogersville	TN
04	03	045420	R	Citizens of Lake Co.	Tiptonville	TN
04	01	041290	R	Morgan Co. Hlth	Wartburg	TN
05	03	052180	R	Rural Health Inc.	Anna	IL
05	07	050030	R	Community Health	Cairo	IL
05	01	053320	R	Southern Illinois	Centerville	IL
05	12	051870	U	Frances Nelson	Champaign	IL
05	02	051720	U	New City Health Ctr,	Chicago	IL
05	02	050080	U	KOMED Health Center	Chicago	IL
05	03	050060	MH	Illnois Migrant	Chicago	IL

Exhibit I(Cont.)

05	06	051050	U	Claretian	Chicago	IL
05	01	053280	U	Near North Health	Chicago	IL
05	07	053210	U	Erie Family Hlth Ctr	Chicago	IL
05	04	052130	R	Christopher Greater	Christopher	IL
05	05	053150	U	Community Health	Decatur	IL
05	04	05004D	R/MH	Shawnee Hlth Svcs	Murphysboro	IL
05	01	052140	R	Henderson Co Rural	Oquawka	IL
05	12	052760	U	Crusaders Central	Rockford	IL
05	06	051020	U	People's Hlth Ctr	Indianapolis	IN
05	12	053200	U	Community Health	Indianapolis	IN
05	05	053110	R/MH	Indiana Health	Indianapolis	IN
05	06	052200	R	Downriver Community	Algonac	MI
05	12	050210	R	Regional Health	Baldwin	MI
05	04	050220	R/MH	MARCHA	Bangor	MI
05	12	052820	R	Monway Citizens	Carleton	MI
05	02	052070	U	Cass CHC	Detroit	MI
05	01	051990	U	Detroit Health Dept	Detroit	MI
05	04	051680	R	East Jordon Family	East Jordon	MI
05	04	053300	U	Hamilton Area	Flint	MI
05	04	052030		Cherry Street Services	Grand Rapids	MI
05	03	053160	R	Thunder Bay, CHC	Hillman	MI
05	01	050290	R	Northern Michigan	Houghton Lake	MI
05	03	056230	U	Family Health Center	Kalamazoo	MI
05	05	051980	R	Alcona Medical	Lincoln	MI
05	03	051440	R	Upper Pennisula	Newberry	MI
05	04	052510	R/MH	Pullman Health	Pullman	MI
05	04	050360	R/MH	Health Delivery Inc.	Saginaw	MI
05	03	050380	MH	Sparta Health Ctr	Sparta	MI
05	04	052250	R	Sterling Area Health	Sterling	MI
05	04	052910	R	Citizens Health	Temperance	MI
05	03	050390	MH	Northwest Michigan	Traverse City	MI
05	06	052710	R	Cook Area Hlth	Cook	MN
05	06	052700	R	Cook Co Clinic	Grand Marais	MN
05	04	051770	U	Indian Hlth Board	Minneapolis	MN
05	03	050320	MH	Migrant Health	Moorehead	MN
05	03	053020	U	Westside Community	St. Paul	MN
05	12	052730	U	Model Cities Health	St. Paul	MN
05	03	050560	R	Barnesville Hlth	Barnesville	OH
05	03	052270	R	P.R.A.V. Health Svcs,	Chillcothe	OH
05	01	051570	U	Cincinnati Health	Cincinnati	OH
05	01	050990	R	South. Ohio Hlth Svcs	Cincinnati	OH
05	01	050580	U	Hough Norwood Fam	Cleveland	OH
05	04	050960	R/MH	Community Hlth Svcs	Freemont	OH

Exhibit I(Cont.)

05	04	050640	R/MH	Family Hlth Service	Greenville	OH
05	05	051660	R	Ironton-Lawrence Co	Ironton	OH
05	02	052900	R	Community Action	Piketon	OH
05	05	053010	U	Toledo Family	Toledo	OH
05	12	051780	U	Cordelia Martin HC/	Toledo	OH
05	08	051490	R	Northern Health Ctrs,	Lakewood	WI
05	06	050840	R	Marshfield Medical	Marshfield	WI
05	04	053060	U	16th Street Clin/HOPE	Milwaukee	WI
05	03	056220	U	Milwaukee Comprehens.	Milwaukee	WI
05	01	052670	U	Indian Hlth Bd of	Milwaukee	WI
05	06	052810	R	North Woods Medical	Minong	WI
05	04	050900	MH	La Clinica De Los	Wildrose	WI
06	01	060940	R	White River Rural	Augusta	AR
06	06	062090	R	Mid-Delta Rural Hlth	Clarendon	AR
06	05	062140	R	CABUN Rural Hlth	Hampton	AR
06	12	060060	R	Lee Co Cooperative	Marianna	AR
06	08	060080	R	Rural Health Inc.	Paragold	AR
06	06	060110	U	Jefferson Comp Care	Pine Bluff	AR
06	02	062730	R	Mainline Health	Portland	AR
06	12	060140	U	East Arkansas Family	West Memphis	AR
06	06	060180	R	Teche Action Board	Franklin	LA
06	08	063380	U	Bayou Comprehensive	Lake Charles	LA
06	08	060190	R	Natchitoches Area	Natchitoches	LA
06	01	062480	R	Catahoula Parish	Sicily Island	LA
06	01	060240	U	Albuquerque Family	Albuquerque	NM
06	07	060330	R	Health Centers of	Espanola	NM
06	08	060360	R	Gallup/Thoreau/Grants	Gallup	NM
06	05	060370	R	Ben Archer Health	Hatch	NM
06	02	062160	R	Centro Rural de	Loving	NM
06	08	061290	R/MH	La Casa de Bueno	Portales	NM
06	07	063010	R/MH	La Clinica de	San Miguel	NM
06	01	063450	R	Presbyterian Med	Santa Fe	NM
06	07	063920	U	La Familia Medical	Santa Fe	NM
06	07	060490	MH	Oklahoma State	Altus	OK
06	08	063930	R	Konawa Community	Konawa	OK
06	02	060530	U	Community Hlth Ctrs	Oklahoma City	OK
06	05	063890	U	Morton Health Center	Tulsa	OK
06	02	062650	R	Panhandle Rural	Amarillo	TX
06	08	061000	R	Chapparral Hlth Clinic	Benavides	TX
06	08	061510	U/MH	Brownsville Comm.	Brownsville	TX
06	04	062120	R/MH	South Texas Rural	Cotulla	TX
06	05	060670	R/MH	Vida y Salud	Crystal City	TX
06	12	061010	U	Martin L. King, Jr.,	Dallas	TX
06	07	060680	U	Los Barrios Unidos	Dallas	TX

Exhibit I(Cont.)

06	12	060710	R/MH	Cross Timbers	De Leon	TX
06	07	060740	R/MH	United Medical Svc	Eagle Pass	TX
06	02	063520	R	Centro Medico Del	El Paso	TX
06	12	061230	U	Centro de Salud	El Paso	TX
06	12	060810	R	Gonzales County	Gonzales	TX
06	08	060820	R	Comm Hlth Svc Agency	Greenville	TX
06	05	060840	R/MH	Su Clinica Familiar/	Harlingen	TX
06	05	061610	U	Galveston Co. Coord.	La Marque	TX
06	04	060900	U/MH	Laredo-Webb Co Hlth	Laredo	TX
06	06	061220	R/MH	South Plains Rural	Levelland	TX
06	08	061260	R	East Texas Community	Nacogdoches	TX
06	08	061190	R	Jasper-Newton Comm	Newton	TX
06	01	060750	R/MH	Hidalgo Co. Health	Pharr	TX
06	06	060950	R/MH	South Plains Health	Plainview	TX
06	08	062390	R	Atascoso RHI Health	Pleasanton	TX
06	04	063190	U	City of Port Arthur	Port Arthur	TX
06	02	060970	R/MH	Comm Action Council	Rio Grande City	TX
06	04	063940	U	Ella Austin Comm.	San Antonio	TX
06	03	062360	U/MH	Barrio Comp Family	San Antonio	TX
06	05	063250	U	Centro Del Barrio	San Antonio	TX
06	08	063910	R/MH	Uvalde Co.-Clinic,	Uvalde	TX
07	03	071170	U	Community Hlth Care	Davenport	IA
07	08	071790	U	Broadlawns Medical	Des Moines	IA
07	02	070050	MH	Muscatine Migrant	Muscatine	IA
07	02	071410	U	Peoples Comm Hlth	Waterloo	IA
07	05	071800	MH	Kansas City Wyandott	Kansas City	KS
07	07	070090	MH	Kansas State Dept	Topeka	KS
07	08	070150	U	Hunter Health Clinic	Wichita	KS
07	12	071660	R	Caldwell Co Medical	Hamilton	MO
07	08	070290	U	Samuel U. Rodgers	Kansas City	MO
07	05	070270	U	Swope Pkwy Comp	Kansas City	MO
07	05	070300	R	NE Missouri Hlth &	Kirksville	MO
07	03	072130	R	Northwest Missouri	Mound City	MO
07	08	071370	R	New Madrid Group	New Madrid	MO
07	12	071670	R	Central Ozark	Richland	MO
07	02	071700	U	Family Care Center	St. Louis	MO
07	06	072100	U	Peoples Clinic	St. Louis	MO
07	02	070370	U	St. Louis Compre	St. Louis	MO
07	03	071190	U	Neighborhood HC, Inc	St. Louis	MO
07	06	070430	R	Big Springs Medical	Van Buren	MO
07	04	070450	MH	Nebraska State Dept	Lincoln	NE
07	03	072110	U	Charles Drew Medical	Omaha	NE
08	12	080030	R/MH	Valley Wide Health	Alamosa	CO

Exhibit I(Cont.)

08	07	081260	R	Gilpin/Columbine	Black Hawk	CO
08	01	081460	U	Comm Hlth of	Colorado Springs	CO
08	01	080010	MH	Colorado Dept. of	Denver	CO
08	01	080060	U	Denver Dept of Hlth	Denver	CO
08	07	080100	R	Dolores Co. Hlth	Dove Creek	CO
08	06	080130	R/MH	Plan de Salud del	Fort Lupton	CO
08	04	080140	R/MH	Sunrise Community	Greeley	CO
08	02	081650	R	La Clinica Campesina	Lafayette	CO
08	08	081740	R	Uncomphadre Combined	Norwood	CO
08	06	080170	U	Pueblo Comm Hlth	Pueblo	CO
08	05	082500	U	Yellowstone City/	Billings	MT
08	02	082160	MH	Montana Migrant	Billings	MT
08	08	083270	R	Butte CHC-Silver Bow	Butte	MT
08	01	082110	R	Mercer-Oliver	Center	ND
08	05	080890	R	Union County Health	Elk Point	SD
08	02	080500	R	NW South Dakota	Faith	SD
08	12	081030	R	East River Health	Howard	SD
08	04	082100	R	Isabel Comm RHI	Isabel	SD
08	08	080590	R	South Dakota Rural	Pierre	SD
08	01	081450	U	Sioux River Valley	Sioux Falls	SD
08	08	081690	R	Tri-County Hlth Care,	Wessington Spring	SD
08	07	082240	R	Wayne Co. Medical	Bicknell	UT
08	08	082480	R	Enterprise Valley	Enterprise	UT
08	08	082490	R	Green River CHC	Green River	UT
08	05	080510	MH	Utah Rural Dev. Corp.	Midvale	UT
08	05	082050	U	Weber County Comm.	Ogden	UT
08	01	080220	U	Salt Lake City Comm	Salt Lake City	UT
08	03	080830	MH	Tri-County Dev. Corp.	Guernsey	WY
08	03	080710	MH	Northwestern Comm.	Worland	WY
09	06	090030	R	West Pinal Family	Casa Grande	AZ
09	12	093030	R/MH	Clinica Adelante,	El Mirage	AZ
09	06	090090	R	Mariposa Community	Marana	AZ
09	07	091300	R	Lake Powell Family	Page	AZ
09	12	093070	U	Memorial Family	Phoenix	AZ
09	08	090130	R/MH	Valley Health Ctr,	Somerton	AZ
09	01	090160	U	El Rio Santa Cruz NHC	Tucson	AZ
09	03	093590	R	United Community	Tuscon	AZ
09	05	090210	R	Family Health Fnd. of	Alviso	CA
09	01	093660	U	Inland Empire CHC	Bloomington	CA
09	06	090250	R/MH	Clinicas de Salud	Brawley	CA
09	12	090260	R	Intermountain Comm.	Brownsville	CA
09	04	091600	R/MH	Buttonwillow Health	Buttonwillow	CA
09	12	093150	R/MH	El Progreso del	Coachella	CA

Exhibit I(Cont.)

09	04	090290	U	Drew Hlth Foundation	East Palo Alto	CA
09	02	093320	U/MH	Sequoia Comm Health	Fresno	CA
09	01	091050	R/MH	La Clinica Popular	King City	CA
09	04	090390	R/MH	Clinica Sierra Vista	Lamont	CA
09	07	091650	R	Long Valley Hlth Ctr,	Laytonville	CA
09	04	093160	U	Arroyo Vista Family	Los Angeles	CA
09	02	091040	U	Asian Pacific Venture	Los Angeles	CA
09	12	093110	U	Altamed	Los Angeles	CA
09	01	090490	U	Community Hlth Fdn	Los Angeles	CA
09	12	090440	U	Watts Health	Los Angeles	CA
09	12	093210	R/MH	El Concilio de Madera	Madera	CA
09	04	090470	R/MH	Merced Family	Merced	CA
09	07	090710	R/MH	Nipomo Comm Med Ctr,	Nipomo	CA
09	04	090540	U	West Oakland Health	Oakland	CA
09	04	091030	U	Asian Health Svcs	Oakland	CA
09	05	091230	U	La Clinica de la	Oakland	CA
09	07	090850	MH	North Sacramento	Olivehurst	CA
09	12	091000	U	Northeast Valley	Pacoima	CA
09	06	090560	R/MH	United Health Ctrs of	Parlier	CA
09	03	093640	MH	Porterville Family	Porterville	CA
09	04	091240	U	West Contra Costa	Richmond	CA
09	01	093120	U	Logan Heights Family	San Diego	CA
09	04	090530	U	San Francisco Med.	San Francisco	CA
09	03	090660	U	Mission Neighborhood	San Francisco	CA
09	01	090670	U	North East Medical	San Francisco	CA
09	01	090720	R/MH	North County Hlth	San Marcos	CA
09	01	091080	U	San Ysidro Health Ctr	San Ysidro	CA
09	07	093080	U	UC Irvine (CCOC)	Santa Ana	CA
09	05	093650	MH	Clinicas del Camino	Saticoy	CA
09	12	090780	R/MH	Agricult'l. Workers	Stockton	CA
09	07	091960	R	Northeast Rural	Susanville	CA
09	01	093190	U	Tiburcio Vasquez	Union City	CA
09	02	091760	R	Commonwealth of Saipan	Saipan	CM
09	05	093530	R	Guam Health Dept.	Agana	GU
09	04	093410	R	K K V Comprehensive	Honolulu	HI
09	03	090990	R	Waianae Coast	Waianae	HI
09	08	091570	R	Central Nevada Rural	Babbitt	NV
09	04	090820	U	CHC of S. Nevada	Las Vegas	NV
09	01	093680	R	Republic of Palau	Koror	PW
09	02	093570	R	Ministry of Health	Marshall Islands	TT
09	01	091920	R	Ponape State Hosp.	Ponape	TT
10	07	100020	U	Anchorage Neighborhd	Anchorage	AK
10	07	101610	R	Glenns Ferry Area	Glenns Ferry	ID
10	04	100160	R	Terry Reilly Health	Nampa	ID

Exhibit I(Cont.)

10	04	100280	R	Mountain Health	Nampa	ID
10	03	101630	R/MH	Valley Family Health	Payette	ID
10	07	100180	R	Health West Inc.	Pocatello	ID
10	03	101650	R/MH	Family Health Svcs,	Twin Falls	ID
10	08	100790	MH	Clinica Del Valle		OR
10	07	100010	R	Southeast Oregon	Chiloquin	OR
10	04	101230	MH	Virginia Garcia Mem	Cornelius	OR
10	03	102080	R/MH	La Clinica del Carino	Hood River	OR
10	07	101120	U	Multnomah Co Dept.	Portland	OR
10	12	100760	U	NW Human Svcs, Inc.	Salem	OR
10	04	100340	R/MH	Salud Medical Center	Woodburn	OR
10	03	100360	R	N E W Health Programs	Chewelah	WA
10	08	100270	R	West Coast Health	Copalis Beach	WA
10	04	101770	MH	Okanogan Farmworkers	Okanogan	WA
10	12	100460	R	Columbia Basin Hlth	Othello	WA
10	08	101520	R/MH	La Clinica/South	Pasco	WA
10	03	100640	U	Puget Sound Neighbor	Seattle	WA
10	04	101020	U/MH	Sea-Mar Community	Seattle	WA
10	03	100630	U	Central Seattle	Seattle	WA
10	06	100450	U	Community Health Care	Tacoma	WA
10	04	101030	R/MH	Yakima Valley Farm	Topennish	WA
10	04	100570	R/MH	N C WASH Mig Health	Wenatchee	WA

Exhibit I(Cont.)

1990 HOMELESS GRANTEES

SECTION 340 HEALTH CARE FOR THE HOMELESS

Project Name:	City:	State:
Charter Oak Terrace/Rice		
Heights Health Center	Hartford	CT
Hill Health Center	New Haven	CT
Southwest Bridgeport Comm. Hlth Ctr.	Bridgeport	CT
Windham Area Comm. Action Prog., Inc.	Danielson	CT
Boston Health Care for Homeless Project	Boston	MA
Springfield Hlth Svs. for the Homeless	Springfield	MA
Worcester Area Community		
Mental Health Center, Inc.	Worcester	MA
City of Manchester Public Health Dept.	Manchester	NH
Providence Ambulatory Hlth Care Found	Providence	RI
Community Hlth Ctr. for Burlington, Inc.	Burlington	VT
William F. Ryan CHC	New York	NY
United Hospital Fund	New York	NY
Bowery Residents Committee		
Human Services, Corp.	New York	NY
Westchester Health Network Neighborhood		
Health Association of Mt. Vernon	White Plains	NY
Newark Homeless Health Care Project	Newark	NJ
Under 21 - Covenant House	New York	NY
St Vincent's Hospital	New York	NY
NY Childrens Health Project	New York	NY
Jersey City Family Hlth Ctr	Jersey City	NJ
San Juan Department of Health	San Juan	PR
Henry J. Austin Hlth Ctr. HCH	Trenton	NJ
Health Care for the Homeless Proj., Inc.	Washington	DC
Health Care for the Homeless	Baltimore	MD
Primary Health Care Services	Erie	PA
Philadelphia Health Mgmt. Corporation	Philadelphia	PA
Primary Care Health Services	Pittsburgh	PA
Rural Health Corporation of NE PA	Wilkes-Barre	PA
The Daily Planet	Richmond	VA
Peninsula Institute for Comm. Hlth	Hampton	VA
Valley Health Systems, Inc.	Huntington	WV
Georgia Hill Street Neighborhood Fac.	Atlanta	GA
Birmingham Hlth Care for the Homeless	Birmingham	AL
Charleston Interfaith Crisis Ministry	Charleston	SC
Chattanooga Hamilton County Hlth Dept.	Chattanooga	TN

Exhibit I(Cont.)

Lincoln Community Health Center, Inc.	Durham	NC
Midlands Center for the Homeless	Eastover	SC
Broward County HCH	Ft. Lauderdale	FL
Jackson-Hinds Comprehensive HC	Jackson	MS
Lexington-Fayette County Hlth Dpt	Lexington	KY
Seven Counties Services, Inc.	Louisville	KY
Memphis Health Center, Inc.	Memphis	TN
Camillus Health Concern	Miami	FL
Pinellas County Department St.	Petersburg	FL
Metropolitan Health Dept.	Nashville	TN
Wake Health Services, Inc.	Raleigh	NC
Tampa Community Health	Tampa	FL
Travelers and Immigrants Aid	Chicago	IL
Crusaders Central Clinic	Rockford	IL
Indiana Health Centers, Inc.	Indianapolis	IN
East Side Promise, Inc.	Indianapolis	IN
Visiting Nurse Services of So. Mich.	Battle Creek	MI
Ingham County Health Dept.	Lansing	MI
St. Mary's Health Services	Grand Rapids	MI
Family Health Center, Inc.	Kalamazoo	MI
Detroit Health Care for the Homeless	Detroit	MI
Downriver Community Services	Algonat	MI
Hamilton Family Health Ctr.	Flint	MI
Hennepin Cty Homeless Assistance Proj.	Minneapolis	MN
West Side Health Center, Inc.	St. Paul	MN
ECCO Family Health Center	Columbus	OH
Cordelia Martin Health Center	Toledo	OH
Cincinnati Health Network	Cincinnati	OH
Federation for Community Planning	Cleveland	OH
Coalition for Comm. Hlth Care	Milwaukee	WI
New Orleans Health Department	New Orleans	LA
Albuquerque Hlth Care for the Homeless	Albuquerque	NM
Community Health Center, Inc.	Oklahoma City	OK
Morton Comprehensive Health Serv. Inc.	Tulsa	OK
Amarillo Hospital District	Amarillo	TX
Dept of Hlth & Human Serv. - Dallas	Dallas	TX
City of Forth Worth Health Department	Fort Worth	TX
Harris County Hospital Dist.	Houston	TX
Guadalupe Economic Services Group	Lubbock	TX
The United Way of San Antonio & Bexar Cty	San Antonio	TX
Community Health Care, Inc.	Davenport	IA
Polk County Health Services	Des Moines	IA

Exhibit I(Cont.)

People's Community Health Clinic, Inc.	Waterloo	IA
Hunter Health Clinic, Inc.	Wichita	KS
Charles Drew Health Center	Omaha	NE
Swope Parkway Health Center	Kansas City	MO
Grace Hill Neighborhood Health Center	St. Louis	MO
Colorado Coalition for the Homeless	Denver	CO
Community Hlth Ctr of Colorado Springs	Colorado Spgs	CO
Health Care for the Homeless	Rapid City	SD
Salt Lake Community Health Ctrs, Inc.	Salt Lake City	UT
El Rio Santa Cruz Neighborhood Hlth Ctr	Tucson	AZ
Maricopa County Dept. of Hlth Services	Phoenix	AZ
The Family Health Foundation	Alviso	CA
Drew Health Foundation	E. Palo Alto	CA
Clinica Sierra Vista, Inc.	Lamont	CA
Logan Heights Family Health Center	San Diego	CA
Merced Family Health Centers, Inc.	Merced	CA
San Francisco Community Clinic	San Francisco	CA
Northeast Valley Health Corp.	Pacoima	CA
Nipomo Community Medical	Nipomo	CA
Sequoia Community Health	Fresno	CA
West Contra Cost HC Corp.	Richmond	CA
WCDCH Hosp. Board, Inc.	Waianae	HI
Sacramento County Health Dept.	Sacramento	CA
Santa Cruz Co. Hlth Svcs Agency	Santa Cruz	CA
Alameda Co. Health Care Svcs Agency	Oakland	CA
Santa Barbara County Hlth Care Svcs	Santa Barbara	CA
Terry Reilly Health Services	Nampa	ID
White Bird Clinic	Eugene	OR
Sea Mar Community Health Ctr.	Seattle	WA
Multnomah County Health	Portland	OR
Metropolitan Development	Tacoma	WA
Central Seattle Community Hlth Ctrs	Seattle	WA
Northwest Human Services	Salem	OR

4250. MINIMUM FEDERAL CRITERIA FOR STATES TO USE IN MAKING
PREADMISSION AND ANNUAL REVIEW DETERMINATIONS ABOUT ADMISSION
TO OR CONTINUED RESIDENCE IN NURSING FACILITIES FOR INDIVIDUALS
WHO HAVE MENTAL ILLNESS OR MENTAL RETARDATION

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) sets forth three sections that address preadmission screening and annual resident review (PASARR) requirements:

- o With respect to new admissions occurring on or after January 1, 1989, §1919(b)(3)(F) prohibits a nursing facility (NF) from admitting any new resident who has mental illness (MI) or mental retardation (MR) (or a related condition), unless the State mental health or State mental retardation authority has determined that, because of his/her physical and mental condition, the prospective resident requires the level of services provided by a NF. In addition, where it is determined that admission to the NF is appropriate, a determination must be made as to whether active treatment is required.

- o With respect to all current residents who have MR or MI and who were admitted prior to January 1, 1989, §1919(e)(7)(B) requires the State mental health or the State mental retardation authority to have reviewed and determined by April 1, 1990:

- Whether or not the resident, because of his/her physical and mental condition, requires the level of services provided by a NF or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 or of an institution for mental diseases (IMD) providing medical assistance to individuals 65 years or older in the case of residents with MI or the level of services of an ICF/MR in the case of residents with MR. In the case of residents with MI, the statute further specifies that the determination made by the State mental health authority must be based on an evaluation performed by an independent person or entity; and

- Regardless of the outcome of the NF level of care determination, whether or not the resident requires active treatment for his/her MI or MR.

Section 1919(e)(7)(B)(iii) requires that PASARR reviews and determinations be repeated on at least an annual basis on all NF residents who have MI or MR.

- o Section 1919(f)(8) requires the the Secretary to develop, by not later than October 1, 1988, minimum criteria for the States to use in making the required determinations on new admissions and current residents and in permitting individuals adversely affected to appeal such determinations. However, §1919(e)(7)(A) requires the States to have a PASARR program in operation by the effective dates regardless of whether the Federal criteria are available.

We have been advised that the plain reading of the statute's language and the absence of any apparent limitations mean that any person with MI or MR must be screened if he or she already resides in or is to be admitted to a NF. Furthermore, the statute does not provide any basis for limiting preadmission screening or annual reviews to only those

individuals who have a "known diagnosis" of MI or MR. In order for facilities and States to protect themselves from the imposition of possible sanctions for failure to identify some individuals who have MI or MR, all individuals applying to or residing in a Medicaid-certified NF should be screened in some fashion to determine if they have MI or MR regardless of the "known diagnosis."

We would note that the statute makes preadmission screening requirements applicable to "new admissions." Thus a screening system which differentiates from admissions to an NF those which are "new" (as opposed, for example, to admissions of individuals who had been inpatients but were admitted to a hospital and are now being readmitted) would comply with the law.

We have also been advised that the statute provides no basis for limiting preadmission screening or annual reviews by method of payment. Therefore, all individuals, regardless of whether they are private payers, Medicare beneficiaries, or Medicaid-eligible individuals, must be screened if they reside in or apply to a Medicaid-certified NF. These requirements do not apply to a facility participating solely in Medicare as an skilled nursing facility (SNF).

Because an IMD can be a NF, and all NFs are subject to the PASARR requirements, we have been advised that NFs which participate in Medicaid as IMDs are subject to PASARR. We note that the definition of a NF set forth in §1919(a) appears to be somewhat inconsistent with the definition of an IMD in that it states that a NF is an institution that "is not primarily for the care and treatment of mental diseases." We believe, however, that the best reading of these two definitions is that a NF can be both a NF and an IMD. In such situations, the NF maintains its status as a certified NF, but the IMD classification applies. That is, when NFs provide IMD services for persons over 65 years of age or inpatient patient psychiatric services for individuals under 21, we consider these facilities in the context of these benefits even though they meet NF requirements. For individuals aged 22 to 64, residence in an IMD precludes them from receiving any Medicaid benefits.

The PASARR requirements do not currently apply to swing beds because the existing swing bed regulations at 42 CFR 482.66(b) list those SNF requirements which swing beds must meet and would need to be revised to include PASARR requirements before they would be applicable. When we revise these regulations, we anticipate requiring that PASARR apply to swing beds.

The statutory PASARR requirements make no specific reference to time frames within which the State mental health and mental retardation authorities must perform the required screenings and make the required determinations. We intend to specify in forthcoming regulations that determinations must be made in a timely manner. We believe that timely action is necessary in order to prevent unnecessary extensions of inpatient hospital stays or inappropriate delays in providing needed services to individuals with MI or MR while they await screening by the State.

To the greatest degree possible a State should interface the PASARR process with other existing or future NF preadmission screening and resident assessment procedures. For example, data compiled as part of the preadmission screening (PAS), which, by definition, takes place prior to admission, may be used in conducting the initial assessment which must be performed on a new resident. Currently, these initial assessments must be performed no later than 14 days after the date of admission. As of October 1, 1990, they will have to be performed within the first 4 days after the date of admission. Similarly, the results of the routine annual resident assessment (or more frequent assessments which are precipitated by a change in the resident's status) may be used for purposes of identifying residents with MI or MR who must be referred to the State mental health or mental retardation authorities for the annual resident reviews (ARRs).

Residents who are subject to annual reviews fall into two groups: 1) all who were previously identified as having MI or MR through preadmission screening or initial reviews and who were, for one reason or another, permitted to enter or remain in a nursing facility; and 2) any other residents who are later discovered to have MI or MR. If a resident, who was either not identified as having MI or MR (and therefore was not referred for further screening) or was found not to have MI or MR as a result of the preadmission screening or initial resident review, is later found to have a previously undiagnosed or a new condition of MR or MI, that individual should be referred to the State authorities for screening and a determination.

We envision that discovery of "new" cases of MR or MI will occur in one of two ways. Unlike MR which has a constant nature, MI frequently has an episodic character. Some NF residents may develop MI while in the NF. Development of a new condition or a significant worsening of an existing condition would be a change in the resident's health status which should trigger a reassessment under current regulations (483.20(b)(4)(iv)). We also anticipate that once the uniform data set is in use for routine annual resident assessments (as required by OBRA '87 as of October 1, 1990), some conditions which had previously been inadequately or incorrectly diagnosed may be detected.

The facility should immediately refer "new" cases of MR or MI to the State mental health or mental retardation authorities. At the State's option, the actual screening may be postponed until the next scheduled resident review session at that facility. If the facility is willing to accept responsibility for meeting the resident's new treatment needs in the short term, it may retain the resident until a State determination has been made. However, if the facility believes it cannot meet the resident's needs, that inability would serve as grounds for a more immediate transfer of the individual to a more appropriate setting.

States should be aware that they are responsible if they fail to screen or review any individuals who genuinely have MI or MR. Facilities are also accountable if they admit or allow any individuals to stay who should have been screened or reviewed but were not (unless, in the case of a continuing resident, the facility has notified the State authorities and is awaiting screening). Therefore, in order to ensure that no one who actually has MI or MR is missed, we would advise the State mental health and mental retardation authorities to perform screenings and make determinations on any individuals when they learn that they are suspected of having MI or MR.

For discussion purposes, these Federal minimum criteria present a two-step process. The first step, which is referred to as Level I, involves identification of individuals who are suspected of having MI or MR and need to be subjected to further screening (through Level II). (See §4250.1.) The second step, Level II, is the actual PASARR process by which determinations are made by the State as to whether the individual requires the level of services provided by a NF or another type of facility and (if required) whether the individual requires active treatment. (See §4250.2.) This discussion of the Level II process is, in turn, broken down into three components: PASARR/NF, PASARR/MI, and PASARR/MR which should provide answers to both statutory questions. (See §§4251-4253.) However, as will be explained in these sections, some of the determinations which are required may be made categorically by the State rather than with respect to individuals.

As noted above, the statute requires that a determination be made as to the need for active treatment for all current residents who have MI or MR, regardless of whether they do or do not need the level of services provided by a NF. For new admissions on or after January 1, 1989, a determination as to active treatment needs is only required if the individual is determined to require NF level of services. Under each level (Identification and PASARR) we are providing criteria for both evaluating residents and making determinations based on the data compiled through the evaluation. (See Evaluation Criteria and Determination Criteria under both levels.)

We are outlining criteria, not process. We propose that each State may develop its own process. If the State chooses, it may require facilities or hospital discharge planners to do the Level I screening and make referrals to the State. Alternatively, the State may retain the Level I function or delegate/contract it to another entity. The statute clearly requires, however, that the administration of the Level II screening, the actual PASARR, is a responsibility of the State mental health and mental retardation authorities although they may do so under contract or by delegation. In the case of individuals with MI, the evaluation phase of Level II must be delegated/contracted to a person or entity independent of the State mental health authority.

This discussion treats this screening process as a whole; however, screening need proceed only so far as is necessary to make the determinations required by the law. Thus, if screening quickly reveals that an individual does not have MI or MR, further evaluation is not necessary to meet the statutory requirement.

We believe that decisions as to appropriate placement for current or prospective residents who have MI or MR are not governed by the availability of placement alternatives. If availability of placements were to be considered, there would have been no purpose for Congress to have allowed States the option of submitting Alternative Disposition Plans (ADPs), as provided for in the statute at §1919(e)(7)(D). The purpose of the ADP provision is to give those States which need additional time to create the alternative placement slots and arrange for the provision of active treatment services the opportunity to continue to be in compliance so long as they are making adequate progress toward developing the needed placement slots and services. Placement by the State of individuals with MI or MR in NFs as a means of avoiding responsibility for provision of the active treatment these individuals need will no longer be tolerated.

4250.1 Level I - Identification (ID) of Individuals With Mental Illness or Mental Retardation.--

A. Purpose.--The purpose of the ID screen is to determine which NF applicants or residents have MI or MR and are subject to PASARR. Because the statute excludes dementias from the definition of MI, individuals with a supportable primary diagnosis of dementia (including Alzheimer's disease or a related disorder) are not subject to PASARR (unless they have a concurrent diagnosis of MR). These individuals with dementia will also be detected through this ID screen.

In using these criteria, States are encouraged to develop and to coordinate this screening process with existing State procedures to identify the needs of individuals who have a diagnosis of MI or MR. Because a large proportion of new NF admissions come from hospitals, States may find it practical to have hospitals perform the Level I screening for prospective residents as part of discharge planning. Alternatively, as States determine appropriate, they may elect to have NFs perform the Level I screening on new admissions as well as on their current residents who must be identified for purposes of referral for annual resident review. However the State chooses to design its Level I process, a system must be in place for identifying all individuals with MI or MR so that the required determinations by the State mental health or mental retardation authority can be made.

B. Definitions.--The following definitions of MI, dementia, and MR are applicable for the Level I (ID) process:

1. Mental Illness.--An individual is considered to have MI if he/she has a current primary or secondary diagnosis of a mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III-R)) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

2. Dementia.--An individual is considered to have dementia if he/she has a primary diagnosis of dementia (as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III-R). As described in DSM-III-R, diagnostic criteria for dementia include:

- (a) Demonstrable evidence of impairment in short- or long-term memory;
- (b) At least one of the following:
 - (1) Impairment of abstract thinking;
 - (2) Impaired judgment;
 - (3) Other disturbances of higher cortical function; and
 - (4) Personality change.
- (c) The disturbance in (a) or (b) significantly interferes with work or usual social activities or relationships with others;
- (d) Not occurring exclusively during the course of delirium;
- (e) Either (1) or (2):

- (1) Evidence from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance; or
- (2) In the absence of such evidence, an etiologic organic factor can be presumed if the disturbance cannot be accounted for by any nonorganic mental disorder.

3. Mental Retardation and Related Conditions.--An individual is considered to have MR if he/she has a level of retardation (mild, moderate, severe or profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983), page 1:

Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

The provisions of this section also apply to persons with "related conditions," as defined by 42 CFR 435.1009, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

- (a) It is attributable to-
 - (1) Cerebral palsy or epilepsy; or
 - (2) Any other condition, other than MI, found to be closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR, and requires treatment or services similar to those required for these persons.
- (b) It is manifested before the person reaches age 22;
- (c) It is likely to continue indefinitely; and
- (d) It results in substantial functional limitations in three or more of the following areas of major life activity:
 - (1) Self-care;
 - (2) Understanding and use of language;
 - (3) Learning;
 - (4) Mobility;
 - (5) Self-direction; and
 - (6) Capacity for independent living.

Any other condition includes autism. (See §4398.)

C. ID Evaluation Criteria.--The State should assure that the ID screening process is in place for determining whether each resident in and each applicant to a NF has MI or MR. The process must meet the following evaluative criteria.

1. For MI.--The individual has a primary or secondary diagnosis of MI and does not have a primary diagnosis of dementia. (See definitions of MI and dementia in §4250.1B).

Because the statutory definition refers to DSM-III-R, we cannot use a MI definition more limited than one which includes all mental disorders listed in DSM-III-R. Therefore, all individuals having a mental disorder listed in DSM-III-R will have to have the required PASARR determinations made with respect to them.

In determining whether an individual has a primary or secondary diagnosis of MI and does not have a primary diagnosis of dementia, the evaluator should use discretion in reviewing patient data. For example, in determining an individual's diagnosis, the evaluator should look behind the diagnostic labels used in the patient records. When no MI diagnosis is indicated, the evaluator should look to see if there is any presenting evidence of MI, including possible disturbances in orientation, affect, or mood. A recent (within the last 2 years) history of MI, if known, should also serve as a clue to the evaluator that he or she should investigate further to see whether the MI is, in fact, a current primary or secondary problem. On the other hand, when evidence of current nonpsychiatric primary and secondary problems is clearly present, an individual should not be labeled MI and be needlessly put through the Level II determination process simply as a result of a past MI. The evaluator should also consider the prescription of a major tranquilizer or psychoactive drug on a regular basis in the absence of a justifiable neurological disorder as an indication that further screening is advisable to uncover masked symptoms. Again, however, such medications may be properly used for patients without a mental disorder; and evidence of drug use need not be taken as an indication that further review is needed when there is a medical justification for its use that is not in connection with a mental disorder.

Because dementias are sometimes misdiagnosed as MI (or vice-versa), the evaluator should examine the charts of individuals diagnosed as having MI or suffering from dementia for the possibility of a misdiagnosis. A diagnosis of dementia should be supported by positive evidence from a thorough mental status examination which focuses especially on cognitive functioning and which is performed in the context of a complete neurological or neuro-psychiatric examination. A neurological examination on its own may corroborate a diagnosis of dementia but is not determinative.

2. For MR or Persons With Related Conditions.--The individual has a diagnosis of MR. (See definition of MR in 4250.1B.)

In evaluating whether an individual has a diagnosis of MR, the person performing the Level I (ID) should investigate whether there is any history of MR or developmental disability in the individual's past. The evaluator should also look for any presenting evidence (cognitive or behavioral functions) that may indicate that the person has MR or developmental disability. Referral by an agency which serves persons with MR (or other developmental disabilities) and which has deemed the individual to be eligible for that agency's services should also be an indication that a State (PASARR) determination is needed.

D. ID Determination Criteria.--The findings of the ID evaluation and interpretation should be used in making a determination as to whether or not the individual has (or is suspected of having) MR or MI and, if so, should be subjected to a Level II (PASARR) screening. There are three possibilities:

1. Criterion - IS MI/MR.--Any individual for whom there is a positive response to the evaluation criteria described in §4250.1C, must not be admitted to or allowed to continue to reside in a Medicaid-certified NF without being determined appropriate for nursing facility placement through the Level II (PASARR) process.

2. Criterion - Dementia.--Individuals who are found to have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) as defined in §4250.1B, as a result of the evaluation criteria described in §4250.1C, are not subject to the Level II (PASARR) process for admission to or continued residence in a Medicaid-certified NF, unless they are also MR.

o Explanation: Section 1919(b)(3)(f)(i) and (e)(7)(G)(i) exclude persons with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) in defining individuals considered to have MI. This exclusion, however, does not apply to individuals with a primary diagnosis of dementia and a secondary diagnosis of MR because the definition of MR in the statute simply refers to a diagnosis of MR and makes no mention of an exclusion for dementia.

3. Criterion - IS NOT MI/MR.--Any individual for whom there is a negative response to all ID evaluative criteria for MR or MI and for whom there is no other evidence of a condition of MI or MR may be admitted or continue to reside in a Medicaid-certified NF without being subjected to a review and determination through the Level II (PASARR) process.

E. Recording Determinations.--There should be a record of the ID determination and the evaluation and interpretation upon which the determination was based in the nursing facility resident's record.

4250.2 Level II - Preadmission Screening and Annual Review (PASARR) for Individuals with MR or MI.--

A. Purpose.--The purpose of the PASARR process is to determine: (1) in the case of each nursing facility applicant with MI or MR, whether the applicant requires the level of services provided by a NF, and (2) in the case of NF resident, whether the resident requires the the level of services provided by a NF or an intermediate care facility for the mentally retarded (ICF/MR), inpatient psychiatric hospital for persons under 21, or an institution for mental diseases (IMD) for individuals 65 and older. For applicants with MR or MI who are found to require the level of services provided by a NF and for all current residents with MR or MI, a second determination must also be made as to whether or not the resident requires active treatment.

As noted in §4250 of this manual, responsibility for Level II (PASARR) determinations rests with the State mental health and State mental retardation authorities although we have been advised that they may delegate the screenings or perform them directly. In the case of individuals with MI, the evaluation phase of Level II must be delegated/contracted to a person or entity independent of the State mental health authority.

Also as noted in §4250 of this manual, we intend to specify in forthcoming regulations that preadmission screenings and determinations must be performed timely in order to prevent unnecessary extensions of inpatient hospital stays or inappropriate delays in providing needed services to individuals with MI or MR while they await screening by the State.

These required determinations only address the appropriateness of placement and the need for services, not the provision of services. Even though §1919(e)(7)(B), which describes the determinations which must be made, refers only to institutional settings, it does not preclude alternative placements. Section 1919(e)(7)(C), lists the choices that must be offered to residents who have resided in a NF for 30 months or more and who are found not to need a NF level of services but to require active treatment. This section clearly envisions the possibility of alternative placement in noninstitutional settings. For those residents who have resided in a NF for less than 30 months and are found to require only active treatment, some other placement (whether institutional or community-based) must be arranged. As noted in §4250, we believe that determinations as to appropriate placement for current or prospective residents who have MR or MI are not governed by the availability of placement alternatives.

B. Definitions.--The following definitions and discussions may assist States in making Level II determinations.

1. Active Treatment.--A continuous program for each client with MR or MI which includes aggressive, consistent implementation of a program of specialized and generic training, specific therapies or treatments, activities, health services and related services, as identified in an individualized plan of care, which has the following characteristics:

- o For individuals with MI, the plan must be developed under and supervised by a physician. The prescribed components of the individualized active treatment program must be provided by a physician or other qualified mental health professionals.

- o For individuals with MR, the individual program plan must be developed and supervised by an interdisciplinary team that represents areas that are relevant to identifying the client's needs and to designing programs that meet the client's needs.

The purpose of the active treatment is--

- o For individuals with MR, to direct them toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; to prevent or decelerate regression or loss of current optimal functional status.
- o For persons with MI who are experiencing an acute episode of severe MI which necessitates 24-hour supervision by trained mental health personnel, to diagnose or reduce the recipient's psychotic or neurotic symptoms which necessitated institutionalization, to improve his/her level of functioning and, whenever possible, to achieve the recipient's discharge from inpatient status at the earliest possible time.

Active treatment for a persons with MR does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. For persons with MI, active treatment does not include intermittent psychiatric services to clients who do not require 24-hour supervision by trained mental health personnel. For both groups, the term active treatment does not include, in the case of a resident of a NF (including residents with MI or MR who are determined to require the level of care provided by a NF), services the facility must provide or arrange for its residents under §1919(b)(4) of the Act (though some of these services clearly would become an integral part of an active treatment regimen if one were required).

Persons with MR or MI who need active treatment should be considered for placement in facilities which most appropriately suit the level of services they need. While NF placement is not prohibited, settings such as an IMD, an inpatient psychiatric hospital, an ICF/MR, or an appropriately supervised community setting must also be considered.

NOTE: Currently we have separate Medicaid definitions for active treatment in the ICF/MR and the psych under 21 contexts (42 CFR §§435.1009 and 483.440 for the ICF/MR benefit and 441.154 for the psych under 21 benefit). Active treatment is also required to be provided in psychiatric hospitals under Medicare. In forthcoming regulations we will need to establish a generic definition or descriptive statement about active treatment because the statute clearly excludes active treatment from NF services. As a result, someone who requires active treatment while in a NF requires something the NF usually would not provide and which the statute considers to be distinct from NF services. Until such time as regulations are promulgated, the above given definition is advisory.

We believe that active treatment is a concept which embraces a wide range of services and involves a complex set of competent interactions among the facility's staff and between the staff and the resident. While some components of an active treatment program may be identified as NF services, other components are services which are more

specialized than those which a NF usually provides. Active treatment, however, is not simply a collection of disparate services: it is a concept that embraces the whole range of services a patient needs. The total effect of active treatment is that the individual components are integrated and directed toward achieving the goals established in each individual resident's plan of care.

The need for integration of services may be best illustrated by specific example. If the plan of care for a particular resident contains a program to modify a certain behavior, every staff member in the facility who interacts with that resident during a 24-hour period must be aware of that program and skilled in implementing it so that he or she can appropriately deal with the undesirable behavior whenever it is manifested and can consistently reinforce the new behavior. It would do the resident with MR or MI little good to have only the psychologist who designed the program and who spends only a fraction of the day with the resident versed in administering the program.

It should be noted that individuals who need mental health services and who are admitted to or retained in a NF must receive them whether or not the State determines they constitute "active treatment" or are of a lesser intensity.

2. Appropriate Placement.--Placement of an individual in a NF may be considered "appropriate" when the individual's needs are such that he/she meets the minimum standards for admission and the individual's needs for treatment do not exceed the level of services which the facility is capable of providing.

NOTE: As stipulated by §1919(e)(7), the first question which must be answered concerning an applicant to or a resident of a NF is whether or not he/she needs the level of services provided by a NF. Section 1919(a)(1) defines a NF as "An institution . . . which is primarily engaged in providing to residents: (1) skilled nursing services . . . ; (2) rehabilitation services . . . ; or (3) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities." In other words, an individual requiring health-related care and services above the level of room and board could be considered to meet this definition.

If meeting the minimum criterion for entrance or residence were the only consideration, few individuals in need of some type of supervision would fail to qualify for NF level of services. However, both the old and new regulations relating to long-term care facilities require that a facility be capable of meeting the total needs of any individual which it admits or retains (the existing regulations are at 42 CFR 442.306 while the new regulations are at 42 CFR 483.25). We also believe that the intent of Congress was both to ensure placement of individuals with MR or MI where their total needs would be best served as well and to provide active treatment to those individuals with MR and MI for whom NF placement is appropriate, either because they have medical

needs, as identified by a prioritized needs assessment, which, despite the need for active treatment, require a NF level of services, or because they fall into the group of long-term residents to whom Congress allowed the choice of staying in the NF even though they do not need the NF level of services but do need active treatment.

Because the provision of active treatment requires a high degree of cross-disciplinary competence for staff to interact with each of these individuals with MR or MI around the clock, as needed, it continues to be our experience that long-term care facilities which are not organized to meet the unique needs of the population with MR or MI exclusively cannot readily provide continuous active treatment. Some NFs, however, may need to develop this capability to meet the active treatment needs of individuals with MR or MI. This may be possible if they were to do so with increased staffing and funding, by the State or some other source. The specialized facilities which normally provide active treatment, such as ICFs/MR and psychiatric hospitals, are equipped, staffed, and funded on an enriched basis so that they can provide it. Since the statute clearly envisions that active treatment can and must be provided in NFs under some circumstances, increased funding will, in most cases, be required to enable the facility to provide the specialized services that these residents with MR or MI need. The statute also clearly distinguishes active treatment from NF services and indicates that FFP cannot be made available for active treatment as NF services.

Although Medicaid payment may not be made for active treatment services as NF services, States may use other Medicaid benefits to fund aspects of active treatment programs for individuals with MI or MR who are in a NF. For example, services provided in the context of the rehabilitation services, clinic services, or physical, occupational, or speech therapy services optional benefits might be used to meet some of the more discrete services required by the resident's active treatment program if these optional services are available under the State plan or the State wishes to add them (subject to the amount, duration and scope and comparability requirements listed in 42 CFR 440, subpart B). Similarly, in providing active treatment for short-term residents who are determined to be inappropriate for continued residence in a NF, the States could use other optional Medicaid services such as case management or personal care services to coordinate some components of an active treatment program or to provide the support services needed for community placement. However, the package of services comprising an active treatment program is not able to be funded as "active treatment" and, as noted above, aspects of the package that fall outside the scope of established Medicaid benefits may not be eligible for FFP.

States should bear in mind that for any individuals with MR or MI who are permitted to enter or allowed to stay in a NF (whether under the PASARR process or by failure to be subjected to PASARR) and who need active treatment:

- o FFP will not be available for active treatment services which are billed as NF services; and
- o facilities will be held responsible for provision of all services which the resident needs (including active treatment needs) through the State's survey and certification processes and Federal oversight surveys.

C. PASARR Evaluation Criteria.--Each State's mental health authority and mental retardation authority should assure that a PASARR evaluation process is established that meets the following criteria:

- o PASARR should be adapted to the cultural background, language, ethnic origin and means of communication used by the person.
- o PASARR programs should contain the minimum Federal evaluative criteria included in:

- PASARR/NF - Minimum criteria for determining level of nursing care service needs for individuals with MI or MR. (See §4251.);

- PASARR/MI - Minimum criteria for determining active treatment needs for individuals with MI. (See §4252.);

- PASARR/MR - Minimum criteria for determining active treatment needs for individuals with MR. (See §4253);

- PASARR/MI/MR - Minimum criteria for determining active treatment needs for individuals with a dual diagnosis of MI and MR. (See §§4252-4253.)

- o Information that is necessary for determining whether it is appropriate for the individual with MI or MR to be placed in a NF or in another appropriate residential and program setting (if a NF resident) should be gathered throughout all applicable portions of the PASARR evaluation. (See discussion on interrelatedness of the three instruments in §4251).

- o Current and relevant assessment information obtained prior to the initiation of the PASARR may be used (e.g., prior evaluations of mental and physical status) if this assessment information is considered to be valid and accurate.

- o As appropriate for individuals with MR or MI, PASARR findings should be:
 - accurate and correspond to the person's current functional status;
 - descriptive (i.e., the presence of diagnosis, numerical test scores, intelligence quotients, developmental levels, etc., in the absence of specific statements which interpret what the diagnosis, scores, quotients, and levels mean in terms of the person's functional status should not be acceptable); and
 - interpreted to the person (or a designated legal representative of the person if he/she is incapable of understanding the PASARR findings), to the family, and to the parent or legal guardian of a minor person, if available.

- o The results of the PASARR evaluation should be described in a report which includes:

-- identification of the name and professional title of the person(s) performing the evaluation(s) and the date on which each portion of the evaluations or assessments was administered;

-- a summary of the person's positive traits or developmental strengths and weaknesses or developmental needs; and

-- if active treatment is needed, identification of the MR and/or mental health services required to meet the person's identified active treatment needs, regardless of the availability of those services.

o Findings from this evaluation should be used by the State mental health or mental retardation authorities in making the required determinations about whether the individual with MI or MR requires the level of services provided by a NF and whether active treatment is needed.

o If a determination is made to permit admission of an individual who requires active treatment, the determination should be supported by specific findings that the NF to which the individual is to be admitted can meet the active treatment needs he or she has.

o The PASARR process should be stopped if at any time during the PASARR it is found that the individual does not have MI or MR or that he/she has a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) and does not have a diagnosis of MR or a related condition.

D. PASARR Determination Criteria.--The relevant statutory provisions require determinations, based on the preadmission screening or annual review evaluation findings, as follows:

1. Can be Admitted to a NF.--Any individual with MR or MI who requires the level of services provided by a NF, whether or not he/she also requires active treatment, can be admitted, if appropriate. (See definition of appropriate placement in §4250.2B for this and all following classifications.) If active treatment is also required, these services will have to be provided in addition to the nursing facility services. These active treatment services will have to be provided largely at other than Federal expense.

2. Cannot be Admitted to a NF.--Any individual with MR or MI who does not require the level of services provided by a NF, regardless of whether or not he/she needs active treatment, should be considered inappropriate for placement and cannot be admitted. (The PASARR/MR and/or PASARR/MI portions of the evaluation which investigate the need for active treatment do not have to be done for this group if NF care is not needed.)

3. Can be Considered Appropriate for Continued Placement in a NF.--Any resident with MR or MI who requires the level of services provided by a NF, regardless of the length of his/her previous stay or whether he/she needs active treatment, can continue to reside there, if appropriate. If active treatment is also required, these services will have to be provided in addition to the NF services. These active treatment services will have to be provided largely at other than Federal expense.

4. May Choose to Remain in the NF Even Though Placement Would Otherwise be Considered Inappropriate.--Any resident with MR or MI who does not require the level of services provided by a NF but does require active treatment and who has resided in a NF at least 30 months may choose to continue to reside in the facility or he/she may choose to receive covered services in an alternative appropriate institutional or noninstitutional setting. Wherever the individual chooses to reside, he/she must be provided with the active treatment services which he/she needs, largely at other than Federal expense. If the resident chooses to stay in the NF, FFP will be available for the NF level of services.

5. Cannot be Considered Appropriate for Continued Placement and Must be Discharged (Short-Term Residents).--Any resident with MR or MI who does not require the level of services provided by a NF but does require active treatment and who has resided in the facility less than 30 months must be discharged in accordance with the transfer and discharge requirements of §1919(c)(2). Active treatment services must be provided by the State to the individual in an alternative setting, largely at other than Federal expense.

6. Cannot be Considered Appropriate for Continued Placement in a NF and Must be Discharged (Long-Term Residents).--Any resident with MR or MI, even though he/she has resided in the NF for 30 months or more, who requires neither NF level of services nor active treatment must be discharged in accordance with the requirements of §1919(c)(2).

The decision trees for the preadmission screening (PAS) and annual resident review (ARR) processes, which are presented on the following page, diagram these statutory placement determinations.

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4251. MINIMUM EVALUATION CRITERIA SPECIFIC TO SCREENING PERSONS WITH MR OR MI FOR THE NEED FOR NF LEVEL OF SERVICES - (PASARR/NF)

The purpose of the PASARR/NF process should be to determine, as a result of a review of the data obtained, whether or not the person with MR or MI, because of his/her physical and mental condition, needs the level of services provided by a NF. (See the definition of "appropriate placement" in §4250.2.)

DATA COMPILATION

The PASARR/NF instrument should assess whether the individual's total needs are such that they can only be met on an institutional basis and, if so, whether the NF is the appropriate institutional setting for meeting those needs. At a minimum the PASARR/NF instrument should include:

- o evaluation of physical status;
 - diagnoses;
 - date of onset;
 - medical history; and
 - prognosis.
- o evaluation of mental status; and
 - diagnoses;
 - date of onset;
 - medical history;
 - medical history; and
 - prognosis.
- o functional assessment (Activities of Daily Living).

DATA INTERPRETATION

The data interpretation phase of the PASARR/NF should attempt to prioritize the residents physical and mental needs and assess the severity of each condition. While the PASARR/MR and PASARR/MI portions of Level II will specifically address the individual's need for active treatment, the presence of certain diagnoses or prognoses under the physical and mental evaluations should serve as indicators during the PASARR/NF process that NF placement is or is not appropriate.

The PASARR/NF and PASARR/MI and/or PASARR/MI processes, while being separate instruments with separate purposes, should not be considered to be mutually exclusive determination processes and should not be conducted in isolation of each other (if both determinations as to placement and active treatment are required). The PASARR process taken as a whole should lead to placement decisions which make sense both by providing individuals who need active treatment with these services and by allowing for delivery of

needed services in the most logical and cost effective manner through specialization (except for the long-term residents who are allowed to stay in NFs). Establishing a hierarchy of patient needs is essential to the placement process. For example, a secondary need for active treatment should not preclude admission or residence in a NF if there is a medical need which requires intensive skilled nursing interventions and the NF is capable of adequately meeting the individual's active treatment needs. Nor should a primary need for a rigorous course of active treatment, which is of such an intensity that it can only be provided in a specialized facility, be subordinated to lesser physical needs which could be met in a NF but could also be served as adequately in a specialized inpatient setting such as an ICF/MR, a psychiatric hospital, or an IMD as they could be dealt with in a NF.

In evaluating the data concerning a client's mental status, the evaluator should bear in mind that not all mental disorders described in DSM-III-R will require active treatment. DSM-III-R describes eight diagnoses under Axis I which, by definition, presents psychiatric diagnoses. Axis II presents patterns of personality defenses and/or developmental problems that one brings to a situation. Axis II diagnoses are not clinical syndromes. When a psychiatric diagnosis is assigned, Axis I represents the clinical syndrome, and Axis II represents those things that should be kept in mind while dealing with the Axis I diagnosis. Many psychiatrists do not consider the Axis II items to be mental illnesses at all.

We believe that minor mental disorders, such as Axis II diagnoses on their own, which do not require active treatment, should not keep people out of NFs. We believe that the determinations as to MI a State is required to make need not all be made with respect to specific individuals. A State could, for example, formally determine that certain minor psychiatric diagnoses such as nail-biting, tobacco abuse (smoking), mild depression, inhibited sexual desire, or hypochondriasis are diagnoses for which active treatment is not needed and that individuals who have these diagnoses are not in need of active treatment. If a State did this, individuals with such diagnoses who need NF care could be admitted to NFs without the need for a further specific individual determination by the State mental health authority as to the need for active treatment.

The State could presumably also determine that certain diagnoses always warrant active treatment and indicate that individuals evidencing these latter diagnoses should always be subjected to an individual PASARR/MI evaluation and determination as to the need for active treatment. We will consider whether to specify in regulations conditions such as the five major mental illnesses on Axis I which require active treatment (i.e., schizophrenic, paranoid, major affective, schizoaffective disorders and atypical psychosis) for which individual screening would always be needed.

The State could also make categorical determinations that certain mental conditions would normally require active treatment services of such an intensity that most, although not all, NFs would be incapable of meeting these needs. In such cases, a more specialized care setting would be the more appropriate placement; and the plan of care in that facility would have to address the totality of the resident's physical and mental needs.

The State should recognize, however, that all DSM-III-R mental illnesses are mental illnesses under any approvable screening system and require determinations, either categorically or individually. All Level II determinations, regardless of how they are arrived at, must be recorded in the resident's record.

Just as the State may make certain advance categorical determinations concerning diagnoses which will or will not require active treatment, the State may also make categorical determinations under Level II concerning certain physical conditions which would normally indicate that the individual would require NF level of services. For example, the State could specify that the presence of certain physical conditions such as terminal illness, convalescence from an acute physical illness, or severe illness (i.e. conditions such as comatose, ventilator dependent, or functioning at a brain stem level; or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, congestive heart failure, or similarly debilitating physical illnesses) normally would require NF level of services. Screening to determine active treatment needs for individuals in these physical need groups (through the PASARR/MI or PASARR/MR components of Level II) should not, however, be categorically waived. To the extent that the resident falling into one of these categories could also benefit from active treatment services while in the NF, these secondary active treatment needs would also have to be met; and the plan of care would need to address all the resident's needs.

There are also cases in which the patient's condition upon screening is such that a definitive determination for placement purposes cannot be made. For example, many individuals with delirium arising as a result of treatment provided during a prior hospital stay may or may not have a diagnosis of mental illness or mental retardation which could affect a placement decision. A State may approve provisional admissions and subsequent reassessment where such cases make an effective preadmission determination impossible and the individual is manageable in the NF setting.

The State could also make an advance determination that individuals "of advanced years" who need both NF level of services and active treatment and who are not a danger to themselves or others may be allowed to decline active treatment in a NF. A decision to provide the resident an option to forego active treatment is left open as to age because some elderly persons with MI or MR can benefit greatly from continued active treatment services. Such a decision should, therefore, be made by the client or his/her representative in consultation with his/her caregivers.

States should note that the "advanced years" option can only apply as a practical matter to individuals with concomitant NF needs. The statute accords long-term residents with MI or MR (those who have resided in a facility for 30 months or more) who do not need NF level of services but do need active treatment the choice of remaining in the NF to receive it. Because the need for active treatment is the only qualifying reason for a continued stay, we believe that individuals in this group should not have an unqualified option of declining active treatment. If a resident in this group were to decline active

treatment, he/she would require no needed services. The resident should understand that if he/she refuses active treatment, the facility would have grounds for discharge since none of the resident's needs require NF care. Most elderly residents with MI or MR, however, are likely to have some need for NF level of services in addition to a need for active treatment and, therefore, would have a choice if the State elected to offer this option.

Finally, a State could make an advance determination with respect to very short stays, for example, for respite purposes or in order to permit alternative arrangements for longer term care to be made that NF care is appropriate. In such cases, as in all others, appropriate treatment would need to be provided during the person's stay in the NF.

4252. MINIMUM CRITERIA SPECIFIC TO THE SCREENING OF PERSONS WITH MI - (PASARR/MI)

The purpose of the PASARR/MI process should be to determine, as a result of the data obtained, whether or not the person with MI needs the implementation of an active treatment program for mental illness.

DATA COMPILATION

A. The PASARR/MI process should include a comprehensive history and physical examination of the person. At a minimum, the examination must address the following areas (if not previously addressed):

- o complete medical history;
- o review of all body systems;
- o specific evaluation of the person's neurological system in the areas of:
 - motor functioning;
 - sensory functioning;
 - gait;
 - deep tendon reflexes;
 - cranial nerves; and
 - abnormal reflexes.
- o In case of abnormal findings which are the basis for a NF placement, additional evaluations should be conducted by appropriate specialists; and
- o If the history and physical examination of the PASARR/MI process are not performed by a physician, then a physician's review and concurrence with the conclusions should be required.

B. The PASARR/MI process should provide a comprehensive drug history of all current or immediate past utilization of medications that could mask symptoms or mimic MI.

C. The PASARR/MI process should include a psychosocial evaluation of the person. At a minimum, this should include an evaluation of the following:

- o current living arrangements;
- o medical and support systems; and
- o If the psychosocial evaluation is not conducted by a social worker, then a social worker's review and concurrence with the conclusions should be required.

D. The PASARR/MI process should include a comprehensive psychiatric evaluation. At a minimum, this evaluation should address the following areas:

- o complete psychiatric history;
- o evaluation of intellectual functioning, memory functioning, and orientation;
- o description of current attitudes and overt behaviors;
- o affect;
- o suicidal/homicidal ideation;
- o degree of reality testing (presence and content of delusions) and hallucinations; and
- o If the psychiatric evaluation is not performed by a physician, then a board-certified psychiatrist's review and concurrence with the conclusions should be required.

E. The PASARR/MI process should include a functional assessment of the individual's ability to engage in activities of daily living and the level of support which would be needed to assist the individual to perform these activities while living in the community. The assessment should determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that NF placement is required. At a minimum, this evaluation should address the following areas:

- o self-monitoring of health status;
- o self-administering and/or scheduling of medical treatments, including medication compliance;
- o self-monitoring of nutritional status;
- o handling money;
- o dressing appropriately; and
- o grooming.

DATA INTERPRETATION

The PASARR/MI process should insure that, based on the data compiled, a board-certified psychiatrist validates the diagnosis of MI and determines whether a program of psychiatric active treatment is needed.

4253. MINIMUM CRITERIA SPECIFIC TO THE SCREENING FOR PERSONS WITH MR (PASARR/MR)

The purpose of the PASARR/MR process should be to determine, as a result of the data obtained in this section, whether or not the person with MR or a related condition needs the implementation of a continuous active treatment program, as defined at 42 CFR 435.1009, "Active Treatment in Intermediate Care Facilities for the Mentally Retarded."

DATA COMPILATION

A. The PASARR/MR process should review the individual's comprehensive history and physical examination results so that the following minimum information can be identified:

- o a list of the individual's medical problems;
- o the level of impact these problems have on the individual's independent functioning;
- o a list of all current medications used by the individual; and
- o current response of the individual to any prescribed medications in the following drug groups:

- hypnotics;
- antipsychotics (neuroleptics);
- mood stabilizers and antidepressants;
- antianxiety-sedative agents; and
- anti-Parkinsonian agents.

B. The PASARR/MR process should assess:

- o self-monitoring of health status;
- o self-administering and/or scheduling of medical treatments; and
- o self-monitoring of nutritional status.

C. The PASARR/MR process should assess:

- o self-help development (such as toileting, dressing, grooming, and eating);
- o sensorimotor development (such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor/perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity);
- o speech and language (communication) development (such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which nonoral communication systems can improve the individual's function capacity, auditory functioning, and extent to which amplification devices (e.g., hearing aid) or a program of amplification can improve the individual's functional capacity);

- o social development, such as interpersonal skills, recreation-leisure skills, and relationships with others;
- o academic/educational development, including functional learning skills;
- o independent living development (such as meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bedmaking, care of clothing, and orientation skills (for individuals with visual impairments);
- o vocational development, including present vocational skills;
- o affective development (such as interests, and skills involved with expressing emotions, making judgments, and making independent decisions); and
- o presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation (including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors).

DATA INTERPRETATION

D. The PASARR/MR process should insure that a psychologist who meets the qualifications of a Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a):

- o identifies the individual's intellectual functioning measurement; and
- o validates that the individual has MR or is a person with a related condition.

E. The PASARR/MR process should review the data collected from this section and identify to what extent the person's status compares with each of the following characteristics commonly associated with a need for active treatment:

- o inability to take care of most personal care needs;
- o inability to understand simple commands;
- o inability to communicate basic needs and wants;
- o inability to be employed at a productive wage level without systematic long-term supervision or support;
- o inability to learn new skills without aggressive and consistent training;
- o inability to apply skills learned in a training situation to other environments or settings without aggressive and consistent training;
- o inability to demonstrate behavior appropriate to the time, situation or place without direct supervision;
- o demonstration of severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety;
- o inability or extreme difficulty in making decisions requiring informed consent; and
- o presence of other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person functional skills.